STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155474	A. BUILDING 01 B. WING	06/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BREMEN HEALTH CARE CENTER	316 WOODIES LANE BREMEN, IN46506

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 06/17/11 Facility Number: 000506 Provider Number: 155474 AIM Number: 100266530 Surveyor: Richard D. Schade, Life Safety Code Specialist At this Life Safety Code survey, Bremen Health Care Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.	K0000	The facility requests that this plan of correction be considered its credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The original building was built in 1982 with the 300 Wing added in 1994 and the 100 East and Lounge completed in 1995. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors. The facility has a capacity of 97 and had a census of 93 at the time of this survey. Quality Review by Robert Booher, REHS, Life Safety Code Specialist-Medical Surveyor on 06/22/11. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

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K0074 SS=E	Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Shower curtains are in accordance with NFPA 701. Newly introduced upholstered furniture within health care occupancies meets the criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3. 19.7.5.1, NFPA 13 Newly introduced mattresses meet the criteria specified when tested in accordance with the method cited in 10.3.2 (3) , 10.3.4. 19.7.5.3 Based on observation and interview, the facility failed to ensure draperies, curtains and valances serving as furnishings were flame resistant in 2 of more than 80 rooms in accordance with LSC 10.3.1. This deficient practice affects any residents, staff and visitors in and near the class room and lounge. Findings include: Based on observation with the facility administrator on 06/17/11 between 2:15 p.m. and 3:10 p.m.,	K0074	K-074It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done:*The corrective action taken for the residents found to have been affected by the deficient practice was*No residents affected by the deficient practice.*.*The corrective action taken for those residents having the potential to be affected by the same deficient practice is*No residents affected by the deficient practice.*The measures put into place and a systemic change made to ensure the deficient practice does not recur is*The nine sets of curtains in the lounge and the window treatments in the classroom have been treated with an approved NFPA fire retardant spray. The facility will perform an audit on	07/17/2011

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	the facility had no evidence or documentation of fire resistance, or being treated with a fire retardant, for three window treatments in the class room and nine sets of curtains in the lounge. The administrator acknowledged at the time of observations, he did not have evidence of fire resistance of materials being treated with a fire retardant. 3.1-19(b)		*one third of the building every month and materials will be treated with fire retardant spray if necessary. All documentation of new and old materials will be kept in a binder.*To ensure the deficient practice does not recur, the monitoring system established isA Performance Improvement indicator has been established which evaluates compliance with documentation regarding flame retardant materials. The Executive Director or designee will complete the indicator monthly for the first quarter and quarterly thereafter with results forwarded to the facility performance improvement committee for further evaluation or resolution.POC Date: 07/17/2011:: ::	
K0143 SS=B	Transferring of oxygen is: (a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; (b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and (c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2 Based on observation and interview, the facility failed to	K0143	K-143 It is the practice of this facility to ensure the highest quality of care	07/17/2011

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	ensure 1 of 1 liquid oxygen storage areas were provided with signage indicating oxygen transferring is occurring. This deficient practice could affect residents, staff and visitors in and near the oxygen storage and transfilling room. Findings include: Based on observation with the facility administrator during the tour of the facility at 3:35 p.m. on 06/17/11, the facility's oxygen storage and transfilling room was not provided with a sign indicating transferring of oxygen was occurring. Based on interview at the time of observation, the administrator acknowledged the transferring of oxygen does occur in the oxygen storage and transfilling room and no sign indicating the transferring of oxygen was occurring in the facility's oxygen storage and transfilling rooms was provided. 3.1-19(b)		is afforded our residents. Consistent with this practice, the following has been done: *The corrective action taken for the residents found to have been affected by the deficient practice was* *No residents affected by the deficient practice.* *The corrective action taken for those residents having the potential to be affected by the same deficient practice is* *No residents affected by the deficient practice.* *The measures put into place and a systemic change made to ensure the deficient practice does not recur is* *The facility has posted a sign by the oxygen storage room that indicates transfilling of oxygen.* *To ensure the deficient practice does not recur, the monitoring system established is* *This is the only oxygen room that the facility has to store oxygen. The transfilling sign has been posted so no further action or monitoring for this deficient practice.* *POC Date: 07/17/2011* :: ::	

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